United Nations A/69/855–S/2015/228

General Assembly
Security Council

Distr.: General
2 April 2015
English
Original: Arabic

General Assembly
Sixty-ninth session
Agenda item 107
Measures to eliminate international terrorism

Security Council
Seventieth year

Identical letters dated 1 April 2015 from the Chargé d'affaires a.i. of the Permanent Mission of the Syrian Arab Republic to the United Nations addressed to the Secretary-General and the President of the Security Council

On instructions from my Government, I should like to convey to you the following information:

On Tuesday, 31 March 2015, terrorist groups carried out a barbaric attack against the village of Mab'ujah in the countryside of Salamiyah. In that attack, the terrorists committed a horrific massacre of the village's peaceful residents, killing more than 60 civilians, the majority of whom were children and women, and gravely injuring dozens of others. The dead had either had their throats cut or had been shot. The terrorist gangs also abducted some of the villagers after they had broken into the peaceful homes of the village and looted, ransacked and burned them.

This latest massacre, which was perpetrated in the peaceful village of Mab'ujah, is a continuation of the savage, systematic acts of terrorism that are being committed in Syria by armed terrorist groups. Certain States, in the service of their own narrow interests, insist on referring to those groups as the "moderate opposition". Those groups include such organizations as Islamic State in Iraq and the Levant, the Nusrah Front, the Free Army, Army of Islam and the Islamic Front. Those States therefore intentionally ignore the crimes committed by these groups, which have made it their vocation to kill and slaughter the peaceful civilians of the Syrian Arab Republic and to mutilate their corpses. The Syrian Arab Republic stresses that such acts of terrorism would not occur were it not for the ongoing, direct support that those terrorist groups, which espouse an exclusionary Wahhabist ideology, receive from countries that shamelessly call themselves the "friends of the Syrian people". Their friendship has caused Syrian civilians to be killed, slaughtered, burned, starved and deprived of water, electricity, food and shelter.

The massacres and the crimes against humanity committed by armed terrorist groups, the latest of which was the Mab'ujah massacre, makes it imperative for, indeed, incumbent on, peace-loving States to take punitive measures against those States that support and fund the indiscriminate terrorism that has been directed

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against Syria and its people for more than four years. The international community is now called on to reaffirm its commitment to combat terrorism and extremist terrorist groups by cooperating and coordinating fully with the Government of the Syrian Arab Republic in the fight against this dangerous blight. It must also provide support to the Government of the Syrian Arab Republic, which is today combating terrorism on behalf of all the peoples of the world, in order to defend humanity, justice, freedom and dignity, and keep at bay the evils of extremism, blind fanaticism and destructive, tyrannical ideology.

The Government of the Syrian Arab Republic affirms its resolve to combat terrorism in Syria and its determination to continue fulfilling its duty to defend the Syrian people and protect it from anything that might threaten its security and safety. It once again calls on the Security Council and the Secretary-General to condemn this criminal act. It also reiterates its call for the Council to shoulder its responsibility to counter terrorism and eliminate its root causes by enforcing implementation of its resolutions on counter-terrorism, including resolutions 2170 (2014), 2178 (2014) and 2199 (2015). The Council should furthermore take every forceful measure possible against those who violate the above-mentioned resolutions by continuing to arm, fund, shelter and train armed terrorist groups, including the regimes of Turkey, Qatar and Saudi Arabia, as well as France and certain other Western countries.

I should be grateful if the present letter could be circulated as a document of the General Assembly, under agenda item 107, and of the Security Council.

(*Signed*) Haydar **Ali Ahmad**
Chargé d'affaires a.i.

United Nations A/69/856

General Assembly

Distr.: General
6 April 2015

Original: English

Sixty-ninth session
Agenda item 10
Implementation of the Declaration of Commitment on HIV/AIDS and the Political Declarations on HIV/AIDS

Future of the AIDS response: building on past achievements and accelerating progress to end the AIDS epidemic by 2030

Report of the Secretary-General

Summary

The global AIDS response has achieved extraordinary gains since 2000, in terms of a halt and the beginning of a reversal in the course of the AIDS epidemic. In 2015, the number of new infections and AIDS-related deaths continued to fall globally while in many settings, risk-taking behaviour has been reduced. Through advocacy for affordable medicines and scaled-up treatment programming, access to lifesaving antiretroviral therapy has improved dramatically and mother-to-child transmission rates continue to fall, resulting in a reduction in the number of children who acquire HIV.

Through these important gains, underpinned by historic breakthroughs in science and impressive commitment, leadership and mobilization, notably by civil society and people living with HIV, and unprecedented local resource co-investment, millions of lives have been saved, paving the way towards a confident statement by the international community that ending the AIDS epidemic as a public-health threat is possible within the next 15 years.

However, the work required to achieve this historic goal is far from over. While most countries are making progress towards reaching the targets set in the Political Declaration on HIV and AIDS: Intensifying our Efforts to Eliminate HIV and AIDS, as contained in the annex to General Assembly resolution 65/277 of 10 June 2011, and relevant Millennium Development Goals, in other countries and regions, progress is slow or sliding backwards.

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Gaps within coverage, funding and efficacy of the AIDS response are resulting in a situation where too many people living with, or at higher risk of, HIV are being left behind. Social and economic inequality and gender-based violence continue to place women and girls at greater risk of HIV infection, and adolescents, young people and children are being seriously let down by the AIDS response. Men who have sex with men, transgender people, sex workers, people who inject drugs, prisoners, migrant workers, people with disabilities, those over age 50 and pregnant women are also being left behind in many parts of the world. Stigmatization of and discrimination against people living with, or at higher risk of, HIV also remain rife in many countries. These challenges, coupled with a lack of resources, inadequate health-care infrastructure and punitive laws, are creating significant barriers to the gaining of access by key populations in certain locations to vital HIV-related services, social protection and legal services, as well as employment and education.

Intensified efforts are needed to build upon the impressive gains of the past and ensure that the global goal of ending AIDS as a public-health threat by 2030 is realized. Modelling by the Joint United Nations Programme on HIV/AIDS (UNAIDS) indicates that the period of the next five years offers a unique window of opportunity for ending AIDS by 2030 through accelerated action and investment. In accordance with this opportunity, UNAIDS is assisting countries in the development and implementation of ambitious "fast track" targets for 2020. These targets include an increase in HIV testing so that 90 per cent of people become aware of their status by 2020, and a treatment target aimed at maximizing the proportion of people living with HIV who achieve viral suppression, as well as related prevention and non-discrimination targets. Reaching these targets will require not only increased resources and strategic investment, underpinned by the principles of global solidarity and shared responsibility, but an inclusive, people-centred approach towards reaching those currently being left behind.

Ending AIDS as a public-health threat by 2030 will demand action extending far beyond the remit of health so as to encompass the mainstreaming of AIDS interventions across the wider post-2015 sustainable development goals. The past 30 years of the AIDS response have illustrated the impact that investment in AIDS can have across the wider development agenda: improving integration and strengthening health services and contributing to the empowerment of women and girls. In the post-2015 era, lessons from the AIDS response should be harnessed and resources targeted, not only to eliminate AIDS as a public-health threat, but to strengthen and improve global health and development efforts generally.

I. Introduction

1. 2015 represents the target year for a range of global commitments which catalysed 15 years of concerted global action across multiple sectors, in the fight against HIV and AIDS.

2. The first explicit global commitment emerged with the inception of the Millennium Development Goals in 2000, when the HIV epidemic was placed firmly in the global development agenda under Millennium Development Goal 6, calling for coordinated global efforts by the international community to halt and begin to reverse the spread of HIV/AIDS by 2015.

3. In 2001 and 2006, this commitment was strengthened by the General Assembly through the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS, respectively. These Declarations provided a comprehensive framework for progress towards achieving Goal 6, while addressing the urgent need for the achievement of universal access to HIV treatment, care and support.

4. On 10 June 2011, the General Assembly adopted the Political Declaration on HIV and AIDS: Intensifying our Efforts to Eliminate HIV and AIDS (Assembly resolution 65/277, annex), which built upon previous commitments within the 2001 Declaration and the 2006 Political Declaration, highlighting 10 priority targets and commitments to ensure universal access to prevention, treatment, care and support by 2015. The United Nations has reported on these targets annually since 2012, monitoring progress in the implementation of the commitments set out in the Political Declaration, while identifying challenges and constraints and recommending action needed to accelerate the achievement of targets.

5. 2015 is the target year for the Millennium Development Goals and most targets set out in the 2011 Political Declaration. The present report will review progress made against targets in the 2011 Political Declaration as well as the Millennium Development Goals, while highlighting the global efforts required to end the AIDS epidemic as a public-health threat by 2030.

II. The global HIV epidemic: a status update

6. Significant global progress continues to be made through the AIDS response. Between 2001 and 2013, there was a 38 per cent reduction in new infections (to 2.1 million) and between 2005 (the year with the highest record number of new infections) and 2013, there was a 35 per cent decline in AIDS-related deaths [1].

7. Access to antiretroviral therapy (ART) has improved, with the number of people who receive such therapy having reached 13.6 million by June 2014 [2]. Of these, 12.1 million people were in low- and middle-income countries [3]. In sub-Saharan Africa, some 86 per cent (63-99 per cent) of people living with HIV who know their status are receiving antiretroviral therapy and about 76 per cent (53-89 per cent) of those enrolled in treatment have achieved viral suppression [1]. Following scaled-up provision of antiretroviral therapy for pregnant women living with HIV, there was a 58 per cent decrease globally in new infections among children between 2002 (the year with the highest recorded number) and 2013 [1].

8. Despite such progress, worrying gaps are emerging in the AIDS response. Although the number of new HIV infections is declining globally, in some regions and countries, the number of new infections are increasing, with the Middle East, Northern Africa and some countries in Eastern Europe showing the most significant increases. Similarly, while HIV infection rates may appear stable in some countries, when they are viewed nationally, the infection rates are, in some cases, increasing in specific locations within those same countries.

9. Specific groups are also being disproportionately affected by HIV in many countries. In some regions, women and adolescent girls are shouldering a disproportionate burden, in terms of risk of transmission, caring for those living with HIV, violence experienced as a result of their HIV status and lack of access to vital HIV prevention, treatment and care services. In sub-Saharan Africa, women constitute 57 per cent of adults (15 years of age or over) living with HIV and acquire HIV from five to seven years earlier than do men [1].

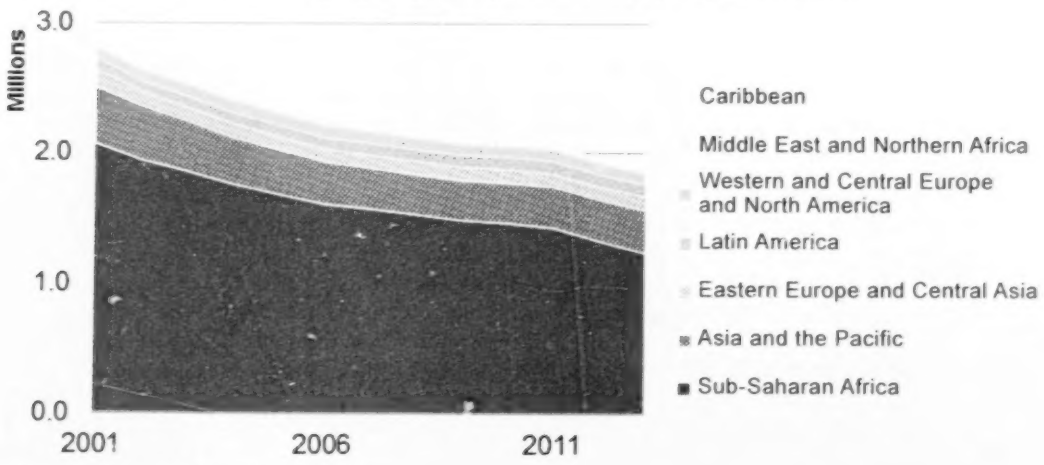
10. Sex workers, men who have sex with men, transgender people, people who inject drugs, migrant workers, adolescents and young people, prisoners, displaced persons, people with disabilities, children and pregnant women and people over age 50 are also experiencing a heightened risk of acquiring HIV. Adolescents and young people are being particularly let down by the AIDS response. In 2013, young people aged 15-24 accounted for 31 per cent of new HIV infections globally, with 57 per cent of those new infections in this age group occurring among adolescent girls and young women [1]. Gaps in treatment coverage and low adherence and retention in care also persist. Despite progress, less than 50 per cent of people living with HIV are receiving antiretroviral therapy [1].

III. Assessing progress towards the 2015 targets and goals

A. Reduce sexual transmission of HIV by 50 per cent by 2015

Figure I

New HIV infections among people aged 15 years or over, by region, 2001-2013



Source: UNAIDS 2013 estimates.

11. The number of adults who are newly living with HIV continues to decline in most parts of the world. At the end of 2013, there were 2.1 million (1.9 million-2.4 million) new HIV infections globally, representing a 38 per cent decrease from 2001 (see figure I) [1].

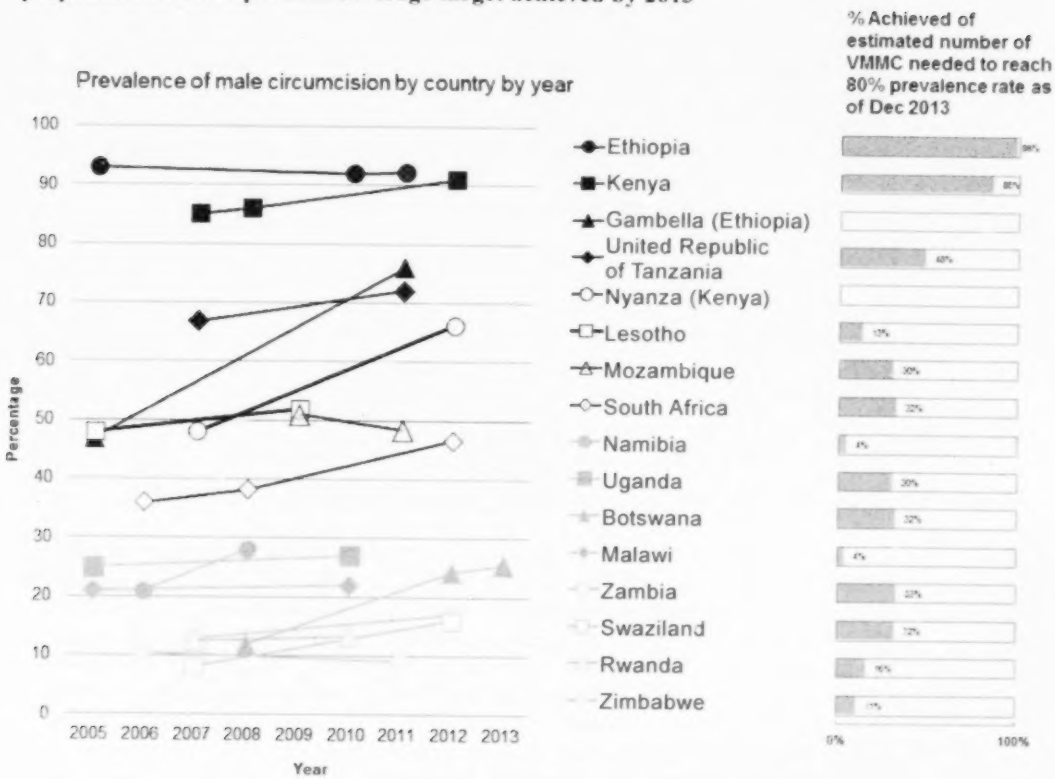
12. Increased uptake of voluntary HIV testing has led to an increase in the number of people living with HIV who know their status (48 per cent in 2013), particularly in countries with the highest burden of HIV infection [1]. Those who know their status are increasingly accessing treatment, with antiretroviral therapy proving a powerful tool in reducing sexual transmission rates. ART methods such as treatment as prevention (TasP) and pre-exposure prophylaxis (PreP) are proving effective prevention tools, having resulted in estimated reductions in HIV acquisition and transmission rates of up to 96 per cent [4] and 86 per cent [5], respectively.

13. Increased male and female condom provision has also shown significant positive results in terms of sexual transmission, although there is still more to be done. Global AIDS response progress reporting (GARPR) by countries in 2014 showed encouraging increases in rates of reported condom use among both men and women in the Congo, Malawi, Mozambique and the United Republic of Tanzania. However, in South Africa, where earlier research linked reductions in HIV incidence in the country to increased condom usage [6], the most recent national survey showed a worrying reduction in condom use.

14. In the past two years, there have been major advances in the scale-up of voluntary medical male circumcision (VMMC), an intervention that could alone avert an estimated 1 in 5 new HIV infections in priority countries (see figure II) [2]. Approximately 1 million men were circumcised in 2013 and a cumulative total of nearly 6 million men had been reached for voluntary medical male circumcision within 14 priority countries by the end of 2013 [2]. While scale-up has occurred in all priority countries, the degree and pace of progress have varied greatly. The most significant progress towards the goal of achieving 80 per cent coverage of male circumcision has been seen in Ethiopia and Kenya, where efforts have been focused on specific provinces. Progress is however lagging in several other priority countries. For example, in Malawi and Namibia, achievements against targets are less than 5 per cent.

Figure II

Prevalence of male circumcision in 14 priority countries, 2005-2013, and proportion of the 80 per cent coverage target achieved by 2013



Source: UNAIDS analysis, based on 2014 GARPR data and national surveys.
Note: No data were available for South Sudan and the Central African Republic.

15. Despite overall gains in reducing sexual transmission of HIV, progress is not reflected in all countries and regions and the target of a 50 per cent reduction in sexual transmission is likely to be missed. In Central Asia and Eastern Europe, new infections rose by 5 per cent between 2005 and 2013 and in the Middle East and Northern Africa, new infections among adults rose by 31 per cent [2].

16. Infection rates among key populations are almost universally high. Indeed, about 40 per cent of all new HIV infections among adults worldwide may occur among people from key populations and their intimate partners [7]. Owing to a range of social and structural barriers preventing access to HIV prevention, testing, treatment and care services, women are experiencing higher HIV transmission rates than men in many countries. Additionally, hostile legal frameworks are serving to alienate certain groups, creating barriers to the accessing of HIV services and sexual and reproductive health and rights and leading to an increase in transmission among key populations.

17. There is an urgent need to accelerate availability of and access to HIV prevention programming (including biological, behavioural, structural and social

responses) which targets key populations that are falling through the cracks of the AIDS response, to be achieved through a refocusing of efforts on key locations where progress is slow. Evidence drawn from evaluations of national social protection programmes has shown that cash transfers help prevent HIV by reducing risky sexual behaviour, particularly among women and girls [8]. In Malawi, for example, a cash transfer scheme of US$ 10 per month for unmarried girls and young women (13-22 years of age) was found to lead to a 60 per cent reduction in HIV risk [9]. Scale-up is also needed in traditional behaviour-change approaches such as community-based peer education, supported by media messaging, comprehensive sexuality education and prevention measures, including increased condom provision.

B. Halve the transmission of HIV among people who inject drugs by 2015

18. It is estimated that there are nearly 12.7 million people worldwide who inject drugs, with injecting drug use found in nearly every country in the world [10]. Approximately 1.7 million, or 13 per cent of the global figure, are living with HIV [1]. In 30 countries surveyed in 2013, HIV prevalence was higher among women who inject drugs than among male injectors, i.e., 13 per cent versus 9 per cent [11].

19. HIV prevalence among people who inject drugs is currently 28 times higher [1] than among the rest of the adult population, making them a high-risk group which is in serious need of focused and coordinated efforts to accelerate progress.

20. Reductions in new infections among people injecting drugs remain conservative at best, with a 10 per cent global reduction between 2010 and 2013 [1]. Thailand, Ukraine and Viet Nam have reported the most significant declines in new HIV infections among people who inject drugs during that time, while in certain countries in Asia and the Pacific, Central Asia and Eastern Europe, slow progress has given way to an apparent rise in HIV prevalence among the members of this group, of between 18 per cent and 31 per cent [1].

21. Despite clear scientific evidence of the impact of harm-reduction programmes, including sterile needle and syringe programmes (NSP) and opioid substitution therapy (OST), on prevention of HIV infection among people who inject drugs, securing commitment and sufficient funding (particularly domestic funding) remains a challenge in many countries. Eighty of 192 countries report that they offer opioid substitution therapy, with only 33 per cent reporting high coverage [12]. This means that only about 26 countries globally provide a level of opioid substitution therapy capable of exerting an impact on HIV transmission among people who inject drugs [13].

22. Globally, sterile needle and syringe coverage is less than 20 per cent in all regions, with a global average of less than two clean needles and syringes distributed per person who injects drugs. Actual need currently stands at 100 times that, i.e., at 200 clean needles per person who injects drugs, per year [14].

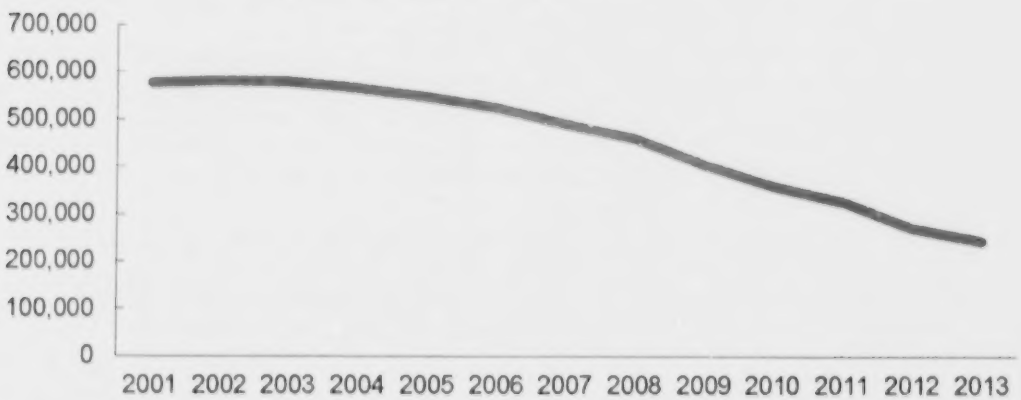
23. Owing to the criminalization of drug possession and use in most countries around the world, drugs policy invariably falls under the authority of law enforcement rather than of health. This often deters or, in some cases, blocks people who inject drugs from accessing health services, including HIV prevention, testing, treatment and care, as well as related sexual and reproductive health and rights. A

World Bank analysis estimates that only about 1 in 10 people who are living with HIV and inject drugs receives antiretroviral therapy [1]. Criminalization has also been shown to lead to human rights abuses in many countries. In Cambodia, China, Malaysia and Viet Nam, many people who use drugs endure involuntary treatment in prisons or in drug detention centres. In turn, confinement further increases the risk of HIV transmission. In some settings, the HIV prevalence among prisoners can reach 50 times that in the general population [14], with inmates, who have little or no access to condoms, sterile needles and syringes or opioid substitution therapy, often engaging in unprotected sex and high-risk injecting behaviour. Fear of police action also serves to make people who use drugs avoid risk reduction measures that might raise suspicion or reveal their activities.

24. All of these factors mean that progress towards the target of halving HIV transmission among people who inject drugs by 2015 is slow. The issue of the lack of accessible, responsive and high- quality harm reduction services for people who inject drugs, both in the community and in prisons, must be urgently addressed. This demands increased commitment to investment as well as engagement of people who inject drugs in the design and delivery of harm reduction services, so as to ensure that those services are responsive to the needs of people who inject drugs. The special session of the General Assembly on the World Drug Problem, to be held in 2016, offers a critical opportunity to build consensus for drug policies that better address the needs of people who inject drugs. Also urgently needed is a significant scale-up of needle and syringe programmes, opioid substitution therapy and other evidence-based drug dependence treatment, HIV testing and counselling and antiretroviral therapy for people who inject drugs. A specific focus on women who inject drugs is recommended in order that vulnerabilities such as stigma, abuse and violence (including intimate-partner violence) may be addressed.

C. Eliminate HIV infections among children and reduce maternal deaths

Figure III
The trend in new HIV infections among children, 2001-2013



Source: UNAIDS 2013 estimates.

25. Significant progress has been made towards the goal of eliminating new HIV infections among children and reducing AIDS-related maternal deaths, following the implementation of recommendations within the Global Plan Towards the Elimination of New HIV Infections in Children by 2015 and Keeping their Mothers Alive (see figure III) [14]. This includes coordinated scale-up of comprehensive services to (a) prevent new HIV infections in women of reproductive age; (b) prevent unintended pregnancies among women living with HIV; (c) prevent mother-to-child HIV transmission; and (d) provide sustained treatment, care and support for women living with HIV, and their children and families.

26. In 2013, 67 per cent of pregnant women living with HIV were receiving antiretroviral therapy to prevent transmission to their children, with a 13 per cent increase in the first six months of 2014 [2]. This has resulted in turn in a 58 per cent decrease worldwide in new HIV infections in children between 2002 and 2013 [1]. It is estimated that, between 2009 and 2013, increased provision of antiretroviral therapy has been responsible for averting more than 900,000 new HIV infections among children [1].

27. However, progress has been uneven and there remain significant gaps in primary HIV prevention for women, including unmet needs for family planning services for women of reproductive age and women living with HIV, particularly in high-burden countries. Additionally, not all pregnant women are accessing antiretroviral therapy; and in many countries, not all pregnant women are being offered HIV testing.

28. There needs to be improvement in respect of continued provision of antiretroviral therapy for breastfeeding mothers during the postnatal period. UNAIDS estimates that more than half of HIV transmission to infants in 2013 occurred during breastfeeding, which is now leading to more mother-to-child transmissions than those related to pregnancy and childbirth. Providing antiretroviral therapy throughout the breastfeeding period can reduce the risk of HIV transmission to infants during breastfeeding. Increased rapid adaptation of the most effective regimen policies, including the offer of a continuation of antiretroviral therapy for life and support for retaining mothers in care, is needed in order to ensure that the children of mothers living with HIV can breastfeed safely and that mothers can lead healthy lives.

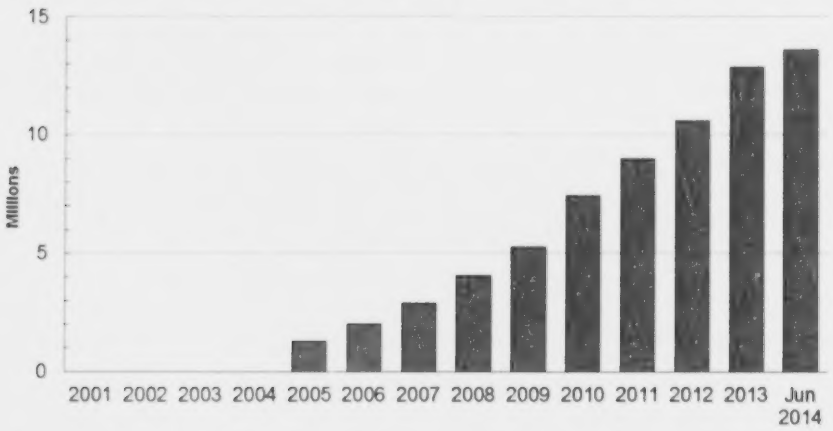
29. Children exposed to or living with HIV are being left behind by services. In 2013, only 42 per cent of HIV-exposed children received early infant diagnostics within two months of birth and only up to one half of those who received diagnostic services received their test results [11]. Children living with HIV are also not accessing treatment, with access to paediatric antiretroviral therapy regimens being far more limited than that for adults. Globally, only 24 per cent of children living with HIV, a total of 762,921, have access to treatment, compared with 38 per cent of adults [1]. Issues related to the formulation of paediatric antiretroviral therapy regimens, such as finding the right dose and the right taste, also remain a challenge. Addressing these issues at its thirty-fifth meeting in December 2014, the UNAIDS Programme Coordinating Board asked UNAIDS to work with relevant partners on establishing a global platform for coordination of the various paediatric treatment initiatives so as to maximize coherence and impact.

30. Reducing the number of new HIV infections in children will be achieved only if additional efforts are made to prevent new infections among women of

childbearing age and reduce the unmet need for family planning among women living with HIV. Urgent, effective adoption of the 2013 World Health Organization (WHO) guidelines on prevention and treatment of HIV infections among pregnant women, mothers and children, coupled with dramatically scaled-up prevention of mother-to-child transmission coverage, could significantly reduce the risk of transmission of HIV to infants, to below 5 per cent [15] while also improving maternal survival. This should be supplemented by provision of increased access to early infant and paediatric diagnosis and treatment, which will require strengthened health systems and mechanisms designed to follow mother-baby pairs, so as to ensure that neither children nor their mothers are overlooked during postpartum and postnatal care.

D. Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015

Figure IV
People receiving antiretroviral therapy, 2005-June 2014, all countries



Source: UNAIDS, Global aids response progress reporting, mid-2014.

31. Since 1995, antiretroviral therapy has averted 7.6 million deaths globally, resulting in the gain of approximately 40.2 million life-years since the start of the epidemic [1]. Following intensive work to leverage the therapeutic and preventive benefits of antiretroviral therapy, the number of people living with HIV who are now accessing lifesaving antiretroviral therapy has increased significantly. A total of 13.6 million people were receiving such therapy globally at the end of June 2014 (see figure IV), setting the world on track for meeting the target of 15 million by the end of 2015. Increases in antiretroviral therapy coverage have been particularly significant in regions where the need is most acute, such as sub-Saharan Africa, which accounts for 3 out of 4 people who are now receiving HIV treatment.

32. While the target of 15 million is within reach, progress has not been consistent globally and significant gaps remain. A total of 22 million people, or 3 in 5 living with HIV, are not accessing antiretroviral therapy [3]. Although the numbers are improving, children and adolescents are being severely underserved: 3 in 4 children

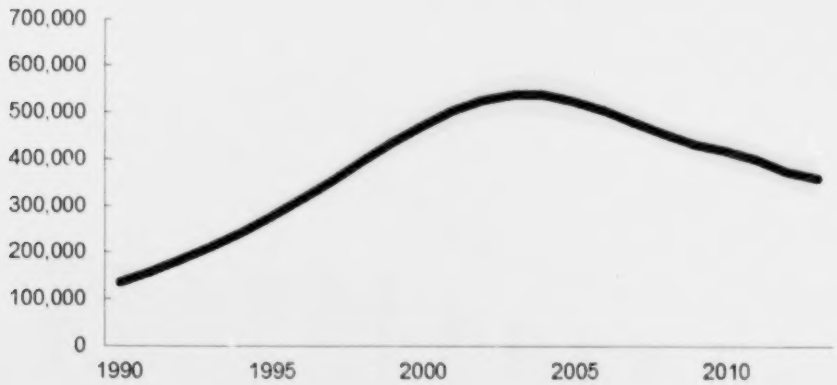
living with HIV are not receiving treatment. Certain key populations, for example, women, are also not accessing and/or adhering to treatment, owing to barriers imposed by the insufficient reach of services, punitive laws, criminalization of behaviours, gender inequality, poverty, fear, stigmatization and discrimination.

33. Costs (particularly of paediatric treatment), ensuring adequate and continued procurement and supply of high-quality, affordable antiretroviral therapy, and negotiating social, legal and human rights constraints, all serve to limit the access to antiretroviral therapy of people living with HIV. Diagnostics are also being underutilized. Of people living with HIV, 52 per cent are not aware of their status [1] and those who have been diagnosed as HIV-positive are not necessarily accessing viral load testing technology [11].

34. Rapid expansion of sustained treatment is needed over the next five years in order to accelerate progress towards ending the AIDS epidemic, particularly for women and girls (and notably breastfeeding women), adolescents and children, people who inject drugs, men who have sex with men and sex workers. To this end, new HIV treatment targets for the post-2015 era were launched at the twentieth International AIDS Conference in 2014. The "90-90-90" targets provide that by 2020: 90 per cent of all people living with HIV will know their HIV status, 90 per cent of all people with diagnosed HIV infection will receive sustained antiretroviral therapy, and 90 per cent of all people receiving antiretroviral therapy will achieve viral suppression. Meeting these targets will require significant strengthening of health systems; smart, focused investment in the interventions that have the highest impact; and increased access to tailored services for all those who are being left behind.

E. Halve tuberculosis deaths among people living with HIV by 2015

Figure V
Deaths among people with HIV/tuberculosis over time, 1990-2012



Source: WHO, *Global Tuberculosis Report 2014*.

35. The number of tuberculosis deaths among people living with HIV has continued to fall globally, to 360,000 tuberculosis deaths among people living with HIV in 2013, representing a 36 per cent [1] reduction since the peak year of 2004

(see figure V). However, it seems unlikely that the world will meet the target of halving the number of such deaths globally by 2015.

36. In 2013, 2.9 million people living with tuberculosis had a documented HIV test result, representing a 15-fold increase in coverage of testing in comparison with 2004. Coverage of tuberculosis testing for people living with HIV varies widely across different countries and regions, ranging from 2 per cent in Indonesia to 98 per cent in Rwanda. Between 2012 and 2013, global progress in coverage of HIV testing for people living with tuberculosis slowed [16].

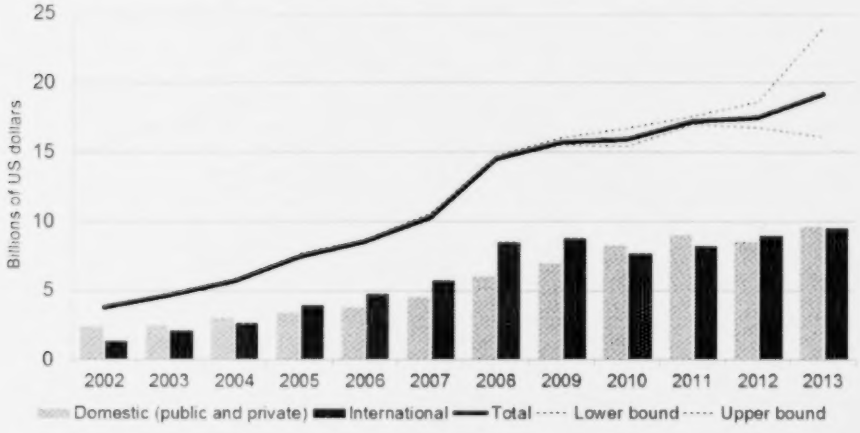
37. People living with HIV remain at much higher risk of tuberculosis co-infection and are 29 times more likely to develop tuberculosis than the rest of the global adult population. In 2013, people living with HIV accounted for 1.1 million (13 per cent) of the estimated 9 million people who developed tuberculosis worldwide. Of those, only 32 per cent were started on lifesaving antiretroviral therapy, meaning that greater efforts in scaling up testing and treatment are needed [16].

38. Innovation is urgently needed to reinvigorate approaches to tackling the co-epidemics of tuberculosis and HIV, through enhancing the reach, timeliness and effectiveness of tuberculosis screening and treatment programmes for people living with HIV. Health-care systems must respond to WHO recommendations on delivering integrated tuberculosis and HIV services, including through providing antiretroviral therapy and co-trimoxazole preventive therapy (CPT) to all people living with HIV and tuberculosis, and putting in place HIV prevention services for people living with tuberculosis, as well as including the offer of isoniazid prevention therapy (IPT) for people living with HIV who do not have active tuberculosis.

F. Close the global AIDS resource gap by 2015

Figure VI

AIDS funding over time, by international and domestic sources (estimates for low- and middle-income countries), 2002-2013



Source: UNAIDS 2014 estimates.

39. While investment in the AIDS response plateaued between 2011 and 2012, at the end of 2013, annual investment in HIV rose to US$ 19.1 billion in low- and middle-income countries, representing a US$ 250 million increase in investment [2]. This increase in resources was driven by a marginal rise in international funding, attributable to the United States Government and the Global Fund to Fight AIDS, Tuberculosis and Malaria, coupled with sustained domestic funding.

40. Between 2006 and 2013, about 75 low- and middle-income countries increased their domestic investments in AIDS by more than 50 per cent. However, the increase in total domestic public funding was slowed by the reduction in spending by a number of countries, because of either lower commodity prices or economic barriers to increases in spending.

41. By December 2014, several countries were either developing or working on sustainable investment plans for their AIDS response, including the refocusing of resources towards high-impact interventions such as those targeting key populations and locations, strengthening commitments to increasing domestic AIDS spending and consideration of innovative financing mechanisms. Private and public sector mainstreaming, where different economic sectors are asked to contribute predefined budget allotments to the HIV response, is being successfully deployed in a number of African countries, with notable successes in Lesotho and Swaziland [17].

42. Lack of stable funding sources for the AIDS response in many countries and projected flattening in international assistance is frustrating progress and threatens to disrupt the scale-up of HIV services. While actual international disbursements rose marginally in 2013, commitments to new funding from traditional funding sources decreased by 3 per cent [18] and there remains a significant gap between the resources needed and the investment made in AIDS resources.

43. Accelerated efforts are needed to ensure that the required levels of funding are achieved, that costs are reduced and that efficiencies are effected to enable fast-tracking towards the end of the AIDS epidemic. Innovative financing mechanisms that are stable, sustainable, progressive, additional and free from major side effects, for economic, political or social development, must be identified if funding goals are to be met. The significant potential of private sector investment should also be harnessed to help close the resource gap.

G. Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV

44. HIV continues to have a disproportionate impact upon women, particularly in high-burden countries and regions. Indeed, HIV is the leading cause of death globally among women of reproductive age. Globally, in 2013, 64 per cent of new infections among young people (15-19 years of age) were among girls [1]. Young women in sub-Saharan Africa who are 15-24 years of age are twice as likely as young men to be living with HIV. The outlook is even worse for female sex workers, transgender women and women who inject drugs or are the partners of men who inject drugs, with higher rates of HIV infection and violence identified in these groups than among women in the wider population.

45. Harmful gender norms and entrenched attitudes of gender inequality are contributing to women's vulnerability to HIV infection in certain settings, through the promotion of unsafe or forced sex, controlling and violent behaviour towards women and multiple sexual partners for men, while preventing women from taking control of their own sexual health and accessing HIV and other sexual and reproductive health and rights services. Unequal access to education, including comprehensive sexuality and HIV education, difficulties securing regular income and employment, and lack of economic security, as well as violence and fear thereof are also increasing women's vulnerability to HIV transmission. This in turn is causing some to participate in high-risk activities, such as transactional sex, while also preventing knowledge of and the sharing of information on HIV status.

46. High levels of gender-based abuse and violence persist in many parts of the world, particularly in many low- and middle-income countries, or regions experiencing recurrent conflict. According to a 2013 WHO report, 1 in 3 women worldwide reports physical or sexual violence, or both, by an intimate partner [19]. Gender-based abuse and violence also affect men and boys (including transgender men) who are perceived as exhibiting non-conforming gender behaviour. In some countries, homophobic rape, also known as "corrective rape", is inflicted on men and women based on the perception of their sexual orientation or gender identity.

47. Research has revealed an association between high levels of violence against women, particularly sexual and physical intimate-partner violence, and increased HIV infection risk among women [20]. Research also indicates that women who are living with HIV are more likely to experience violence as a result of their sero-status. In a survey conducted in the United Kingdom of Great Britain and Northern Ireland of 191 women living with HIV, 50 per cent reported that they had experienced intimate-partner violence [21]. Other forms of violence against women living with HIV include institutional violence and human rights violations, such as forced or coerced sterilization or abortion (sometimes imposed as a condition for receiving antiretroviral therapy) and denial of reproductive health care, including family planning services.

48. While the commitment to eliminating gender inequality and gender-based violence and abuse has yet to be fulfilled, demonstrable albeit fragile gains are being made. A total of 100 of the 109 countries reporting in 2013 indicated that elimination of gender inequalities was a national priority; and the number of countries with policies, laws or regulations adopted to reduce violence against women, including sexual assault, rose among consistently reporting countries, from 90 per cent in 2012 to 92 per cent in 2014 [22]. Leadership capacity of women and girls living with or affected by HIV was also strengthened in 68 countries between 2012 and 2013, while some countries have been scaling up national funding for male engagement so as to promote gender equality. However, the proportion of countries reporting participation of women living with HIV in formal planning and review mechanisms for national AIDS responses declined from 66 per cent in 2010 to 61 per cent in 2012 [22].

49. While commitments by national Governments are encouraging, there is an urgent need for a more consistent translation of those commitments into robust actions. Intensified national and international action to protect women and girls from sexual and gender-based violence is an urgent necessity, as is investment in the leadership and involvement of women in future AIDS strategies. Studies show that

women's economic empowerment increases their power to negotiate safer sex, and contributes to their ability to afford and access HIV testing and counselling services as well as antiretroviral treatment [23]. Empowering women as "agents of change" by reserving space for their participation in key agenda-setting platforms as well as mobilizing grass-roots participation must therefore be prioritized.

H. Eliminate HIV-related stigma, discrimination, punitive laws and practices (promoting laws and policies that ensure the full realization of all human rights and fundamental freedoms)

50. While data from countries with more than one available Demographic and Health Survey indicate some increase in the proportion of accepting attitudes towards people living with HIV, from a median of 37 to 51 per cent among women and from 45 to 55 per cent among men, HIV-related stigmatization and discrimination remain rife in many countries around the world.

51. Stigmatization and discrimination, as well as punitive laws, policies and practices, foster significant human rights violations, promote fear and prevent those who are at risk of HIV infection, as well as those living with HIV, from accessing the legal protection and redress, information and services that they need. As a result of stigma and discriminatory attitudes, people living with HIV, as well as key and at-risk populations, are denied health care, are refused or lose employment and education opportunities and are ostracized by their families and communities. One in 8 people living with HIV report being denied health services and 1 in 9 is denied employment because of his or her HIV-positive status. The People Living with HIV Stigma Index shows that people living with HIV experience unemployment rates that are three times higher than national unemployment rates [1].

52. Criminalization of key populations also remains widespread. Sixty per cent of countries report administering laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and high-risk groups. A total of 79 countries criminalize same-sex sexual relations, while most countries criminalize some aspect of sex work and drug use. Over 60 countries have laws that specifically criminalize HIV non-disclosure, exposure and transmission. Overly broad prosecutions of people living with HIV, including for acts that pose no risk of HIV transmission, have occurred in at least 49 countries.

53. Research shows that fear of stigma and discrimination, which can also be linked to fear of violence, discourages many people living with HIV from disclosing their status even to family members and sexual partners, thereby undermining their ability and willingness to access and adhere to treatment. Research also indicates that where punitive laws related to sex work are in place, sex workers have lower HIV-related knowledge and access to services and higher HIV prevalence [24].

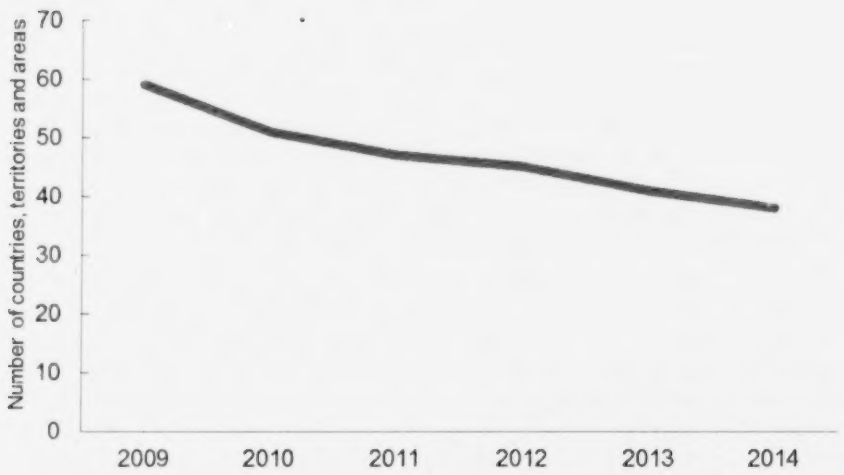
54. In many countries, national HIV programmes are paying increased attention to human rights issues, while working towards the goal of zero discrimination. For example, Morocco and Thailand have developed national HIV plans with concrete objectives centred around reducing stigma and discrimination and human rights violations as well as embracing the key human rights programmes provided for in the 2011 Political Declaration on HIV and AIDS. A total of 103 out of 109 countries have identified the elimination of stigma and discrimination as a national priority

and 61 per cent of countries have reported the existence of anti-discrimination laws that protect people living with HIV [25].

55. Immediate steps need to be taken to enable the review of legal and policy frameworks so as to bring them in line with human rights obligations and international labour rights instruments. Programmes designed to reduce HIV-related stigma and discrimination should help empower people living with or affected by HIV socially and economically, particularly women and girls, who are often subject to one or more types of stigma and discrimination. Programmes should be implemented in ways that promote equality, non-discrimination, accountability, and participation and inclusion of key populations and people living with HIV.

I. Eliminate HIV-related restrictions on entry, stay and residence

Figure VII
Number of countries, territories and areas with HIV-related travel restrictions, over time



Source: UNAIDS, 2014.

56. The 2011 Political Declaration made the removal of all HIV-related restrictions to entry, stay and residence a key priority in efforts towards zero discrimination (see figure VII). Following technical support and political engagement by UNAIDS, three countries from different regions (Australia, the Comoros and Tajikistan) lifted their restrictions or clarified that they did not have restrictions in 2014, joining some 140 countries, territories and areas imposing no HIV-related travel restrictions.

57. While freedom of movement for people living with HIV is expanding, there are still 38 countries, territories and areas that maintain some form of HIV-related travel restrictions. Of these, 18 authorize the deportation of foreigners found to be living with HIV [26]. Migrant workers are particularly affected by HIV-related restrictions on entry, stay and residence. For example, many countries in the Middle

East impose mandatory HIV testing on migrant workers seeking either to secure or to renew work visas. Not only do these practices undermine open international recruitment and risk undermining national efforts to address HIV, but they also infringe on rights to health, privacy and dignity.

58. Accelerated progress is needed in the areas of law and regulatory reform in countries that maintain these restrictions.

J. Strengthen HIV integration (into wider global health and development work)

59. Significant strides have been made in eliminating parallel systems by integrating HIV into wider health systems and development efforts. In many countries, work has begun to integrate HIV services with tuberculosis, sexual and reproductive health and rights — including maternal health, family planning, sexually transmitted infections, cervical cancer and gender-based violence — and child health services. In Rwanda, work towards the elimination of mother-to-child HIV transmission has led to the integration of HIV services and other sexual and reproductive health and rights services, through which maternal and newborn child health services, family planning, HIV counselling and testing, antiretroviral therapy, and services for gender-based violence and sexually transmitted infection are offered within single health facilities.

60. Despite encouraging levels of commitment to integration, there is further work to be done, with many countries at different stages of the process. Enhanced leadership and commitment to eliminating parallel systems are needed, as well as joint planning and implementation, investment in the delivery of integrated services (including infrastructure, training, management, and monitoring and evaluation) and improved cross-sector collaborations. Greater integration is needed between HIV services — including antiretroviral therapy — and treatment of non-communicable diseases. Greater linkages are also needed between HIV services and the non-health sectors, including social protection, employment, food security, human rights, law enforcement and judiciaries, poverty reduction, education and social services.

61. As the integration of HIV services into wider health and development agendas progresses, focused efforts must be sustained to ensure that the specific needs of those living with HIV continue to be addressed and met. It is also important that the approaches to achieving services integration are responsive to the epidemics and affected populations in individual countries, so as to ensure that the integrated response is tailored to local contexts.

IV. Contributing to the achievement of the Millennium Development Goals

Goal 3: Promote gender equality and empower women

62. Promoting gender equality and empowering women constitute an integral part of the global AIDS response. While there is a long way to go in meeting targets related to gender equality and empowerment of women, HIV interventions are beginning to demonstrate their impact in this area. For example, cash transfers for the economic empowerment and retention in education of women and girls are

having a direct impact upon risk-taking sexual behaviour. However, more needs to be done to advance women's empowerment and address the structural gender barriers and negative power relationships that influence the ability of women and girls to confront the challenge of HIV. Critical action is needed to ensure that young women and girls can access and remain in education; that women feel safe and have control over their own sexual health; that women are engaged to a greater extent in leadership, decision-making and service provision; and that there is greater promotion of women's legal rights and access to justice.

Goal 4: Reduce child mortality and Goal 5: Improve maternal health

63. The AIDS response has contributed to the achievement of goals related to child mortality and maternal health through a number of health interventions. Integrated HIV and sexual and reproductive health and rights services have been critical to the progress made towards achieving target 5B of the Millennium Development Goals, which is to achieve universal access to reproductive health. While mortality rates in children under 5 have been improved through reduced mother-to-child transmission of HIV, there is a long way to go towards ensuring that children who are already living with HIV are able to receive treatment.

Goal 6: Combat HIV/AIDS, malaria and other diseases

64. Increased condom use and knowledge of HIV, through scaled-up behaviour change programming, have spurred significant progress towards achieving targets 6A and 6B. While the number of children who have lost one or both parents to AIDS remains staggeringly high — in 2013, the global tally rose to 17.7 million, 15.1 million of whom live in sub-Saharan Africa [3] — recent investments in interventions to mitigate the impact of AIDS on households and communities have had an impressive effect. Today, there is near parity in school attendance of orphans and that of non-orphans aged 10-14.

V. AIDS in the post-2015 era

Fast-tracking to the end of the AIDS epidemic by 2030

65. There is a global consensus that the tools now exist for making an end to the AIDS epidemic by 2030 a distinct possibility. UNAIDS modelling indicates that the next five years provide a vital window of opportunity for achieving this goal, through accelerated action and investment. However, uneven progress, continued stigmatization and discrimination, gender inequality, punitive laws, insufficient and unstable funding, and lack of adequately targeted HIV prevention, treatment and care for key populations mean that many are being left behind. If the global community fails to tailor its response so as to address need where it is most acute, by accelerating efforts with the required energy, the danger exists that the epidemic will re-emerge stronger than ever.

66. Experience has shown that ambitious targets drive progress, enhance accountability and unite stakeholders. To that end, the Joint United Nations Programme on HIV/AIDS, in addition to working with countries on developing and implementing the 90-90-90 treatment target, is developing complementary prevention and non-discrimination targets for 2020. If met, these ambitious yet

achievable targets will effectively end the AIDS epidemic as a public-health threat by 2030, averting 18 million new HIV infections and 11.2 million deaths [2].

67. To generate the momentum needed to make ending the public-health threat represented by the AIDS epidemic a reality, front-loaded investment and rapidly accelerated prevention programming which target key locations and populations are urgently required over the next five years. This programming should include the promotion of correct and consistent condom use, voluntary medical male circumcision programmes, cash-transfer programming and outreach programming with sex workers, men who have sex with men, transgender people and people who inject drugs. In addition, sex workers, men who have sex with men, sero-discordant couples in high-prevalence settings and young women in extremely high prevalence settings should be assured access to pre-exposure prophylaxis.

68. In order for need to be addressed, in tow-income countries, an estimated sum of US$ 9.7 billion in annual investment is required by 2020, while in middle-income countries investment must reach US$ 8.7 billion. In order to achieve this level of investment, all low- and middle-income countries must increase domestic funding to a level that reflects their HIV burden. Lower middle income countries will need to move towards greater self-financing of the response, although those with a heavy HIV burden will continue to require considerable donor support. Upper middle income countries should take immediate steps to begin the transition towards self-financing of the response.

69. Ending the epidemic demands a targeted, dynamic and sustainable response that leaves no one behind. This includes commitment from all stakeholders to strong, flexible health systems, innovative funding mechanisms and cost-effective strategic allocation of funding that targets people in greatest need, or at highest risk, with high-impact interventions. Short-term political priorities must be readjusted so to ensure that policies and programmes are put in place that will generate long-term health, development and economic returns. These approaches should in turn be underpinned by the protection and promotion of human rights and gender equality, as well as the principles of global solidarity and shared responsibility. The High-level Meeting of the General Assembly on HIV/AIDS, due to be convened in 2016, offers a potentially transformative opportunity to strengthen global resolve and redouble strategic efforts to bring the epidemic to an end.

AIDS and the post-2015 sustainable development agenda

70. The future returns of fast-tracked investment in the AIDS response are not limited to the AIDS epidemic. AIDS-driven investment in integration and strengthening of health systems has a direct impact upon a range of other sustainable development challenges. The Ebola virus disease outbreak in West Africa brought the value of AIDS-related health system investment and improvement and the expertise possessed by those involved in the AIDS response into sharp focus. Expertise derived from the AIDS response was quickly leveraged in 2014, through voluntary redeployment of Joint Programme staff to worst-affected countries as well as missions of the Secretary-General and the Executive Director and Deputy Executive Director of the Joint United Nations Programme on HIV/AIDS. In its resolution 2013/11 of 22 July 2013, the Economic and Social Council recognized the value of lessons learned from the global AIDS response for the wider sustainable development agenda (para. 8)

and also recognized that the Joint Programme offered the United Nations a useful example of how to enhance strategic coherence, coordination, results-based focus and country-level impact post-2015 (para. 9).

VI. Recommendations

71. In order to build upon the achievements of the past and realize the opportunities of the future, commitment to the following actions is needed from international funding sources, national Governments, civil society, the United Nations system and other key partners:

- Specific locations and populations that are currently being left behind must be the focus of efforts in the context of the post-2015 AIDS response, so as to ensure that resources and programming are targeted and responsive to need, as well as grounded in human rights and gender equality. People living with HIV and key populations must be fully engaged in the AIDS response, through active participation in defining priorities and implementing programmes.

- A strong focus on AIDS should continue into the post-2015 era, so as to ensure that current gains are preserved and built upon and that, given the opportunity offered, the goal of ending the AIDS epidemic by 2030 is realized. This includes ensuring that linkages with the AIDS response are promoted across the post-2015 sustainable development agenda, particularly in the areas of poverty reduction, employment creation and empowerment of women and girls.

- The goal of achieving zero discrimination must be rigorously pursued. Indicators for measuring reductions in stigmatization, discrimination and human rights violations must be developed and monitored. Systems must also be put in place for identifying and addressing human rights violations so as to enable treatment and prevention of new HIV infections and protect the dignity of those living with or affected by HIV. Training of legal professionals, including those providing support to people living with or affected by HIV, is also crucial [27].

- Social protection programmes that enhance HIV prevention, treatment, care and support, with a particular focus on cash transfer programmes for young women in countries with a high prevalence of HIV [28], should be scaled up for maximum impact.

- Efficiencies must be achieved, wherever possible, to ensure that resources are used effectively and so as to exert the highest impact on those in need. This includes work to improve follow-up and ensure sustained adherence to treatment.

- The future success of the AIDS response in the post-2015 era hinges upon the full funding of the response. Countries should be encouraged to increase their domestic funding in line with their economic status and their experience of the epidemic. For low-income countries, the majority of resources will need to continue to be provided by donor countries. International funding sources should reaffirm their commitment to supporting the AIDS response in the post-2015 era, in line with the principles of global solidarity, shared responsibility and good governance. To this end, upper middle income countries should in

turn begin to transition towards self-funding the major part of their national response.

- Investment by the private sector should be expanded through the replication and upscaling of proved public-private partnerships formed in response to AIDS.

- The knowledge, expertise and lessons learned, as derived from the global AIDS response, should be harnessed within the post-2015 era to assist in solving other complex sustainable development challenges. This includes benefiting from the lessons learned through considering the unique approach of the Joint United Nations Programme on HIV/AIDS in terms of its enhancement of strategic coherence, coordination, results-based focus, inclusive governance and country-level impact.

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